Department of HUMAN SERVICES

Home- and Community-Based Services
Physical Disability Waiver
Information Packet

The Medicaid Home- and Community-Based Services Physical Disability Waiver (HCBS PD) provides service funding and individualized supports to maintain eligible persons in their own homes or communities who would otherwise require care in a medical institution. Provision of these services must be cost effective.

In addition to home and community-based waiver services, the Physical Disability Waiver enrolled members have access to Medicaid covered services and benefits. Medicaid covers a broad array of health services, in addition to the services provided by the waiver, limits out-of-pocket costs. These include, but not limited to, primary care, behavioral health services, skilled nursing care, dental, vision, and emergency care. Most of Iowa's Medicaid members are served by the managed care program called IA Health Link. Managed care organizations coordinate your care.

If you need assistance, please contact Iowa Medicaid Member Services at **1-800-338-8366** or locally in the Des Moines area at **515-256-4606**, Monday through Friday, from 8 a.m. until 5 p.m.

*For telephone accessibility assistance if you are deaf, hard-of-hearing, deaf-blind, or have difficulty speaking, call Relay Iowa TTY at **1-800-735-2942**.*

General Parameters

- All HCBS waiver services must be provided in integrated community-based settings.
- The services that are considered necessary and appropriate to meet the member's needs will be determined through an interdisciplinary team (IDT) consisting of the member, case manager, or Community-based Case Manager, providers, and other persons the member chooses.
- All members will have a comprehensive service plan collaboratively developed with the IDT. The plan documents agreed upon goals, objectives, and service activities.
- Each member will have an individualized comprehensive service plan (ISP) collaboratively developed with the IDT. This plan documents the agreed upon goals, objectives, and service activities. Also collaboratively developed with the IDT, is an individual crisis plan that is designed to enable the member to prevent, self-manage, alleviate or end a crisis.
- The member must have a physical impairment as their disability.
- Members shall access all other services for which they are eligible, and which are appropriate to meet their needs as a precondition of eligibility for the PD waiver.
- A comprehensive service plan must be developed before implementation of services and reviewed and updated annually.
- The member must choose HCBS services as an alternative to institutional services.
- In order to receive PD waiver services, an approved PD waiver service provider must be available to provide those services.
- Medicaid waiver service cannot be simultaneously reimbursed with another Medicaid waiver service or a Medicaid service.
- PD waiver services cannot be provided when a person is an inpatient of a medical institution.
- The member must need and use, at a minimum, one unit of waiver service during each calendar quarter of the calendar year.
- The total cost of PD waiver services cannot exceed $ 730.90 per month, excluding the cost of home and vehicle modification.
- The member must be eligible for Medicaid under SSI, SSI-related, FIP, or FIP-related coverage groups or eligible under the special income level of 300 percent of the maximum monthly Supplemental Security Income coverage group consistent with a level of care in a medical institution.
- Following is the hierarchy for accessing waiver services:
    1. Private insurance
    2. Medicare
    3. Medicaid and/or EPSDT (Care for Kids)
    4. PD waiver services
- Assistance may be available through the In-Home Health-Related Care (IHHRC) program and the Rent Subsidy program in addition to services available through the PD waiver.

Member Eligibility Criteria

Members may be eligible for HCBS PD waiver services by meeting the following criteria:

- Be an Iowa resident and a United States citizen or a person of foreign birth with legal entry into the United States.
- Be between the age of 18 through 64 years.
- Have a physical disability.
- Be blind or disabled as determined by the receipt of Social Security Disability benefits or by a disability determination made through the Division of Medical Services.
- Be ineligible for the HCBS ID waiver.
- Be determined eligible for Medicaid (Title XIX). Members may be Medicaid-eligible before accessing waiver services or be determined eligible through the application process for the waiver program. Additional opportunities to access Medicaid may be available through the waiver program even if the member has previously been determined ineligible.
- Be determined by the Iowa Medicaid Enterprise, Medical Services to need one of the following levels of care:
  - Intermediate care facility (ICF)
  - Skilled nursing facility (SNF)
- For the consumer choice option, not be living in a residential care facility.

Service Descriptions

Please note:
HCBS PD waiver services are designed to be flexible to meet the needs of each member. However, decisions regarding what services are appropriate and the number of units or the dollar amounts of the appropriate services is based on the member's needs as determined by an interdisciplinary team.

Consumer-Directed Attendant Care (CDAC)

What: Assistance to the member with self-care tasks that the member would typically do independently if the member was otherwise able. An individual or agency, depending on the member's needs may provide the service. The member, parent, guardian, or attorney-in-fact under a durable power of attorney for health care shall be responsible for selecting the individual or agency that will provide the components of the CDAC services to be provided.

The CDAC service may include assistance with non-skilled and skilled services. The skilled services must be done under the supervision of a professional registered nurse or licensed therapist working under the direction of a physician. The registered nurse or therapist shall retain accountability for actions that are delegated.

Skilled services may include, but are not limited to:

- Tube feedings,
- Intravenous therapy,
- Parenteral injections,
- Catheterizations,
- Respiratory care,
- Care of decubiti and other ulcerated areas,
- Rehabilitation services,
- Colostomy care,
- Care of medical conditions out of control,
- Postsurgical nursing care,
- Monitoring medications,
- Preparing and monitoring response to therapeutic diets, and
- Recording and reporting of changes in vital signs.

Non-skilled services may include, but are not limited to:

- Dressing,
- Hygiene,
- Grooming,
- Bathing supports,
- Wheelchair transfer,
- Ambulation and mobility,
- Toileting assistance,
- Meal preparation,
- Cooking,
- Eating and feeding,
- Housekeeping,
- Medications ordinarily self-administered,
- Minor wound care,
- Employment support,
- Cognitive assistance,
- Fostering communication, and
- Transportation.

This service is only appropriate if the member, parent, guardian, or attorney-in-fact under a durable power of attorney for health care has the ability to and is willing to manage all aspects of the service.

Where: In the member's home or community. Not in the provider's home.

Does not include: Daycare, respite, room and board, case management or supervision. CDAC cannot replace a less expensive service.

An individual CDAC provider cannot be the recipient of respite services provided on behalf of a member receiving HCBS services.

The cost of nurse supervision, if needed

Unit: A unit is 15 minutes.

Maximum units: The case manager or MCO CBCM working with the member and the interdisciplinary team, establishes a dollar amount that may be used for CDAC. The amount is then entered into the comprehensive service plan along with information about other HCBS services the member may receive. This monetary information is also entered into the service plan along with the responsibilities of the member and the provider and the activities for which the provider will be reimbursed. The member and the provider come to agreement on the cost per unit. A completed copy of the Agreement is distributed to the member, the provider, and the case manager/MCO CBCM. The Agreement becomes part of the comprehensive service plan. These steps must be completed **before** service provision.

Provider enroll: The provider must be enrolled with the Department and certified as a CDAC provider **before** the completion of the *HCBS Consumer-Directed Attendant Care Agreement*.

It may be important for the member to enlist more than one CDAC provider. Back up services may be necessary in case of an emergency.

Home and Vehicle Modification (HVM)

What: Physical modifications to the home and vehicle to assist with the health, safety, and welfare needs of the member and to increase or maintain independence. All modification requests are reviewed individually, and a determination is made regarding the appropriateness of the modification request.

Where: In or on the member's home or vehicle. **Please note that only the following modifications are included**:

- Kitchen counters, sink space, and cabinets
- Special adaptations to refrigerators, stoves, and ovens
- Bathtubs and toilets to accommodate transfer, special handles and hoses for showerheads, water faucet controls, and accessible showers and sink areas
- Grab bars and handrails
- Turnaround space adaptations
- Ramps, lifts, and door, hall, and window widening
- Fire safety alarm equipment specific for disability
- Voice activated, sound activated, light activated, motion activated, and electronic devices directly related to the member's disability
- Vehicle lifts, driver specific adaptations, remote start systems, including such modifications already installed in a vehicle
- Keyless entry systems
- Automatic opening device for home or vehicle door
- Special door and window locks

- Specialized doorknobs and handles
- Plexiglas replacement for glass windows
- Modification of existing stairs to widen, lower, raise or enclose open stairs
- Motion detectors
- Low pile carpeting or slip resistant flooring
- Telecommunications device for people who are deaf
- Exterior hard surface pathway
- New door opening
- Pocket doors
- Installation or relocation of controls, outlets, and switches
- Air conditioning and air filtering if medically necessary
- Heightening of existing garage door opening to accommodate modified van

Does not include: Modifications which increase the square footage of the home, items for replacement which is the responsibility of the homeowner or landlord, vehicle purchase, fences, furnaces, or any modifications or adaptations available through regular Medicaid.

Purchasing, leasing or repairs of a motorized vehicle are excluded.

Unit: A unit is the cost of the completed modification or adaptation.

Maximum: The member is eligible for up to $6592.66 per year.

Personal Emergency Response System (PERS)

What: An electronic device connected to a 24-hour staffed system which allows the member to access assistance in the event of an emergency.

A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

Where: The PERS or portable locator is based in the member's home and includes an electronic device used by the member.

Unit: A unit is one time installation fee ***and/or*** one month of service.

Maximum Units: Twelve months of service per state fiscal year (July 1 – June 30).

Specialized Medical Equipment

What: Medically necessary equipment (as determined by a medical professional, i.e., PT, OT, nurse, licensed psychologist, speech therapist, etc.) for personal use by the member, which provides for the safety and health of the individual but are normally not funded by Medicaid; educational system or vocational rehabilitation programs; and are not provided by voluntary means.

Specialized medical equipment shall include medically necessary items which are for personal use by members with a physical disability and which:

- Provide for the health and safety of the member by members with a physical disability and which:
- Are not ordinarily covered by Medicaid,
- Are not funded by educational or vocational rehabilitation programs, and
- Are not provided by voluntary means.

Coverage includes, but is not limited to:

- Electronic aids and organizers
- Medicine dispensing devices
- Communication devices
- Bath aids
- Non-covered environmental control units
- Repair and maintenance of items purchased through the waiver

Where: In the member's home or community. Not in the provider's home.

Unit: A unit is the cost of the item.

Maximum Up to $6592.66 per year may be allocated for the purchase and repair of specialized medical equipment.

Transportation

What: Transportation services may be provided for members to:

- Conduct business errands,
- Complete essential shopping,
- Receive medical services not reimbursed through medical transportation,
- Travel to and from work or day programs, and
- Reduce social isolation.

Where: In the community as identified in the comprehensive service plan.

Does not include: Cost of medical transportation reimbursable through non-emergent medical transportation funding.

Unit: The units are per mile, per trip.

Consumer Choices Option

What: The **Consumer Choices Option (CCO)** is an option that is available under most HCBS waivers. This option will give you more control over a targeted amount of Medicaid dollars. You will use these dollars to develop an individual budget plan to meet your needs by directly hiring employees and purchasing other goods and services.

CCO offers more choice, control, and flexibility over your services, as well as more responsibility. Additional assistance is available if you choose this option. You will choose an Independent Support Broker who will help you develop your individual budget and help you recruit employees.

You will also work with a financial management service that will manage your budget for you and pay your workers on your behalf. Contact your case manager for more information. Additional information may also be found at the website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/consumer-choices-option.

Services that may be included in the individual budget under CCO are:

- Consumer-directed attendant care (unskilled)
- Home and vehicle modification
- Specialized medical equipment
- Transportation

Where: In the member's home or community. Not in the provider's home.

Does not include: CCO cannot be used to pay for:

- Room and board,
- Workshop services,
- Other childcare, and
- Personal entertainment items.

Goods and services provided through CCO cannot otherwise be provided through Medicaid state plan services. Goods and services would:

- Decrease the need for other Medicaid services,
- Promote inclusion in the community, or
- Increase your safety in your home and community.

Unit: A monthly budget amount is set for each member

Application Process

The application process for the PD waiver requires a coordinated effort between DHS and non-department agencies on behalf of the prospective member. If you are currently working with DHS personnel, please contact that person regarding the application process.

Please respond immediately to correspondence from an income maintenance worker or case manager/MCO CBCM. This will decrease the amount of time needed to complete the application process and assist in communication.

1. Application for Medicaid (Title XIX) and the PD waiver is made with an income maintenance worker (IM) at the local DHS office.

   Upon availability of a payment slot, the IM worker will process the application and refer the member to a Medicaid case manager or DHS service worker (MCM).

For individuals applying for the PD waiver, an appointment will be scheduled with the IM worker. Documentation necessary for this application may include the following

- Medical records that indicate a physical disability
- Financial records
- Title XIX card
- Letter of Medicaid eligibility
- Verification of Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI) or State Supplemental Assistance (SSA) eligibility, if applicable. If assistance is not currently being received, a request may be made to apply at the local Social Security office.

2. The applicant will be contacted to schedule an assessment. The interRAI assessment must be completed as one of the eligibility requirements for the waiver. The assessor will send the completed assessment to the Iowa Medicaid Medical Services unit. The Iowa Medicaid Medical Services unit will review the submitted documentation and make a determination as to whether or not the applicant meets the level of care.

3. The Iowa Medicaid Medical Services will review the interRAI assessment tool to determine if the member's needs require intermediate or skilled level of care.

   If the member does not meet level of care, the IM will send a *Notice of Decision (NOD)* notifying the member of the denial. The member has the right to appeal the decision. The appeal process is explained on the *NOD*.

4. An assessment must be completed annually. If the member is enrolled with an MCO, then the MCO will make the annual level of care determination after the assessment is completed. If the member is FFS, then Iowa Medicaid will make the annual level of care determination after the assessment is completed. Iowa Medicaid retains the final determination authority for all level of care determinations.

5. An interdisciplinary team meeting is conducted to determine the services that are needed, the amount of service to be provided, and the providers of the services. The interdisciplinary team meeting will be attended by the member, the case manager, community-based case manager (CBCM), PD waiver service providers, and other support persons the member may choose to attend. The end result of the interdisciplinary team decisions will be a comprehensive service plan developed, signed and dated by the case manager or community-based case manager.

6. For MCO enrolled members, the MCO must approve the comprehensive service plan and authorize services.

7. For Fee For Service members (FFS) the Individualized Services Information System (IoWANS) process must be completed with the culmination of an approved comprehensive service plan before the implementation of services. An approved comprehensive service plan recorded in the IoWANS system authorizes payment for waiver services for FFS members.
8. The Medicaid case manager or MCO will issue a Notice of Decision if the member is approved to receive BI waiver services

Estate Recovery

Estate recovery legal reference: 441 IAC 75.28(7)

Estate recovery applies to all persons who have received Medicaid on or after July 1, 1994, and are age 55 or older, or who live in a medical facility and cannot reasonably be expected to return home. This includes members on waiver programs such as the Elderly Waiver Program and Medically Needy Program.

When a Medicaid member dies, assets from their estate are used to reimburse the state for costs paid for medical assistance. This includes the full amount of capitation payments made to a Managed Care Organization (MCO) for medical and dental coverage, regardless of service use or how much the managed care entity paid for services.

Additional information may also be found at the website:
https://dhs.iowa.gov/ime/members/members-rights-and-responsibilities/estate-recovery

or contact:

Medicaid Member Services Toll Free: 800-338-8366
515-256-4606 (Des Moines area)
or
Iowa Estate Recovery Program Toll Free: 1-877-463-7887
8:00 a.m. – 5:00 p.m., Monday – Friday

Discrimination is Against the Law

The Iowa Department of Human Services (DHS) complies with applicable federal civil rights laws to provide equal treatment in employment and provision of services to applicants, employees, and clients and does not discriminate on the basis of race, color, national origin, age, disability or sex. DHS does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

DHS:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Iowa Medicaid Member Services at 1-800-338-8366.

If you believe that DHS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: DHS, Office of Human Resources, by emailing contactdhs@dhs.state.ia.us or in writing to:

DHS Office of Human Resources
Hoover State Office Building, 1st floor
1305 East Walnut Street
Des Moines, IA 50319-0114

You can file a grievance in person, by mail, or email. If you need help filing a grievance, the DHS Office of Human Resources is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue
SW Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al ***1-800-338-8366 (TTY: 1-800-735-2942).***

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-338-8366 (TTY: 1-800-735-2942).**

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-338-8366 (TTY: 1-800-735-2942).**

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite **1-800-338-8366** (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: **1-800-735-2942**).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-800-338-8366 (TTY: 1-800-735-2942).**

مصلا مكبلاو:***1-800-735-2942***). ةظوحلم: اذإ تنك ثدحتت ركذا ةغللا، نإف تامدخ ةدعاسملا ةيوغللا رفاوتت كل ناجملاب. لصتا مقرب ***1-800-338-8366*** (مقر فتاه

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ **1-800-338-8366 (TTY: 1-800-735-2942).**

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-338-8366 (TTY: 1-800-735-2942)** 전화해 주십시오.

ध्यान द : य द आप हदी बोलते ह तो आपके िलए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह।
1-800-338-8366 (TTY: 1-800-735-2942) पर कॉल कर ।

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-338-8366 (ATS: 1-800-735-2942).**

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call **1-800-338-8366 (TTY: 1-800-735-2942).**

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-800-338-8366 (TTY: 1-800-735-2942).**

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-338-8366 (TTY: 1-800-735-2942).**

ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤ ကညီ ကျိာ်အဃိ, နမၤနှ့် ကျိာ်အတ်မၤစၢၤလ၊ တလၫ်ဘူဉ်လၫ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး **1-800-338-8366 (TTY: 1-800-735-2942).**

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-338-8366** (телетайп: **1-800-735-2942**).